STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING: _____ B. WING _____	01/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKENAZI HEALTH	720 ESKENAZI AVENUE INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for a state hospital complaint investigation. Complaint: #IN00131629 -Unsubstantiated -lack of sufficient evidence. Survey Date: 1/22/14 Facility # 005023 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor William N. Wishard Hospital is in compliance with 410 IAC 15-1.5-2; Infection Control, 410 IAC 15-1.5-8; Physical Environment, 410 IAC 15-1.5-1; Dietetic Services, 410 IAC 15-1.5-7; Pharmacy Services, and 410 IAC 15-1.5-6; Nursing Service for Indiana Hospital Licensure rules. QA: claughlin 02/07/14	S 000		